Tab 6 - Prioritizing Subpopulations

Statewide Uniform Priority Setting Process

There are currently six HIV Prevention Community Planning Groups (CPGs) in Texas representing six plan areas. Each of the CPGs is responsible for the creation of an area action plan (AAP). A uniform process for priority setting was developed in 1996 by a statewide CPG workgroup. Over time, this process has been streamlined and simplified for community planners. The statewide process includes the use of uniform definitions, format, factors, and data sources. The process incorporates the following principles/standards:

1. use of a uniform priority setting process and tools with uniform criteria and weights for prioritizing subpopulations;
2. use of standardized worksheets and matrices to create a score for each subpopulation. This score will be used to begin discussion and reach agreement on identified priorities in the Area Action Plan (AAP);
3. categorization of subpopulations into three Behaviorally Defined Target Populations (BDTPs) as the primary modes of exposure for contracting HIV/AIDS, as reflected in each Area Epidemic Profile;
4. HIV/AIDS morbidity as the clearest indicator of disease incidence and to be given the most weight for ranking subpopulations, followed by behavioral risk data derived from prevention counseling sessions, and the option to use needs assessment data to increase the behavioral risk score by 25%; and
5. use of a standardized client survey and resource inventory instrument in all plan areas to assure the collection of uniform data elements across the State. (See instruments in the Appendix.) CPGs may supplement these tools in order to collect additional data for assessing needs in each plan area.

Behaviorally Defined Target Populations

What is a Behaviorally Defined Target Population (BDTP)?

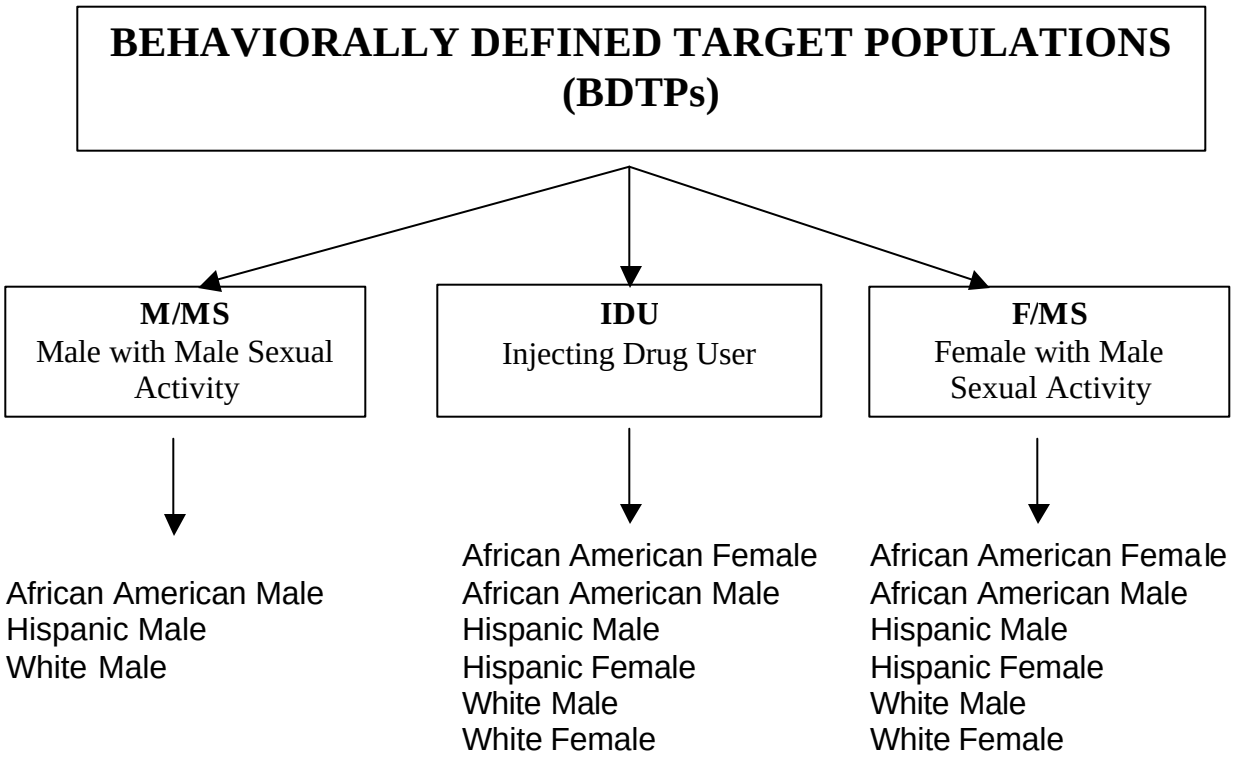
BDTP is a term that refers to groups of people who are at high risk for HIV transmission because they engage in certain behavior(s) such as intravenous drug use and/or unprotected anal or vaginal sex. These groups are the focus of HIV prevention efforts because the behaviors correlate with high rates of HIV infection as evidenced in HIV epidemiologic data and reported by clients who are HIV positive. The following three BDTPs are used to categorize groups at highest risk for HIV in the State of Texas:

M/MS (Male with Male Sex): Persons at highest risk of contracting HIV through male-to-male sexual activity.

IDU (Injecting Drug Users): Persons at highest risk of contracting HIV through injecting substances directly into their bodies by using a needle and syringe (including M/MS who inject drugs).

F/MS (Female with Male Sex): Persons at highest risk of contracting HIV through male-to-female or female-to-male sexual activity. Examples include sex trade workers, substance abusers, persons with a history of STDs, persons with multiple sex partners, and persons with partners who inject drugs, engage in male-to-male sexual activity, are currently HIV positive, or have multiple sex partners.

CPGs are asked to prioritize subpopulations based on a breakout of the three BDTPs into race, ethnicity, and gender, which results in a total of fifteen (15) subpopulations, as noted in the diagram below.



Targeted Subpopulations

What are Targeted Subpopulations?

Targeted subpopulations are groups of individuals who share similarities but are distinguished from the rest of the BDTP through race, ethnicity, gender, age and/or other categories, including behaviors (such as sex worker). By breaking out BDTPs into targeted subpopulations, CPGs can specifically define who is in greatest need for prevention resources and how to select interventions to serve them. A list of subpopulations is provided in each Area Epidemic Profile. CPGs used this list and the detailed information about each sub-population as the basis for the priority setting process. CPGs were not limited by the list, however; data gathered through the needs assessment process may have substantiated the need to further refine the subpopulations. For example, data may indicate that a subset of a subpopulation may need to be targeted, such as *adolescent M/MS* or *F/MS sex workers*. If the needs assessment results suggested that one of the subpopulations listed in the Area Epidemic Profile need further refinement, CPGs could request additional morbidity and risk data on that subgroup to assist in the priority setting process.

On the other hand, CPGs had the option to combine subpopulations within a BDTP if data was similar. For example, if supporting data for all race and ethnicities of female IDUs are similar, CPGs may have combined those subpopulations into one, which would then be listed in the Area Action Plans as female IDUs.

Prioritizing (Ranking) Subpopulations

This section explains the factors used in the process for ranking subpopulations. Needs assessments and CPG discussion can be used (with documented justification) to shift priorities, identify new high-risk subpopulations, and combine targeted subpopulations once they have been ranked initially.

Scoring Factors:
1) Morbidity Score (see Area Epidemic Profile for data sources utilized)
2) Behavioral risk score (CTS data – see Area Epidemic Profile)
3) Needs assessment results (see Tab 5)

Scoring Ranges/Weights:
Morbidity score: 0 – 112 (multiplied by 3 = 0 - 336)
Behavioral risk score: 0 – 111 (can be increased by 25%)
Needs assessment results: 25% of behavioral risk Score

Scoring Formula:
Morbidity score (x3) + risk score (+25% if applicable) = final ranking
Maximum Ranking: 336 + 111 (1.25) = 475

How is the Planning Area divided for prevention planning?

Each planning area is divided into clusters of counties by disease prevalence. The clusters of counties with higher numbers of reported cases of HIV/AIDS or STD are called **High Morbidity Analysis Zones (HMAZ).** Each planning area may have one or more HMAZs, and each HMAZ is profiled separately to guide community planners in decision-making about which populations should be targeted in different parts of each planning area. The rest of the counties in each planning area are combined into a **Low Morbidity Analysis Zone (LMAZ)**.

Which subpopulations have morbidity and risk scores assigned?
Morbidity data on subpopulations, divided by sex, race/ethnicity, and risk behaviors were analyzed for the following groups:

- M/MS African Americans
- M/MS Hispanics
- M/MS Whites
- IDU African Americans, males and females separately
- IDU Hispanics, males and females separately
- IDU whites, males and females separately
- F/MS African Americans, males and females separately
- F/MS Hispanics, males and females separately
- F/MS whites, males and females separately

TDH then calculated a *morbidity* (disease*) score* for each of these subgroups. The following data sets were included in these scores:

- AIDS cases diagnosed in each group in 1998 (as of 10/19/1999)
- HIV infections reported from 1/1/1999 through 10/19/1999
- AIDS cases reported as living as of 10/19/1999
- Positives from prevention counseling providers for 1998 (as of 3/11/1999)
- Cases of primary and secondary syphilis, gonorrhea, and chlamydia diagnosed in 1998

How were the morbidity scores calculated?
1. TDH calculated rates for each subpopulation on each of the data sets named above since population sizes vary. Population sizes were estimated. Details on how rates were calculated can be found in Appendix 3 of the Area Epidemic Profile.
2. Each rate then was assigned a score on a scale of 1 to 16, with higher rates receiving higher scores. The rates and scores for each plan area can be found in Appendix 1 of the Area Epidemic Profile.
3. Scores for each subpopulation were then totaled for all the data sets and then "ranked" from highest to lowest. The higher the disease score, the greater the burden of disease in the subpopulation. (More detailed information on how the

scores were calculated and examined is found in the introduction to Appendix 1 of the Area Epidemic Profile.)

4. If data was available, CPGs could request the calculation of morbidity scores on additional subgroups of subpopulations, such as adolescents.

How were the behavioral risk scores calculated?
TDH also calculated a *risk score* for each of the subpopulations based on risk behavior information reported by prevention counseling providers for clients seen in 1999. Scores were based on the percentage of clients in each of the subpopulations reporting the following risks in the 12 months prior to the HIV counseling session:

- 'Almost never' using barriers with anal, vaginal, or oral sex (each type of sex examined separately)
- Multiple sexual partners
- Sex partner(s) had multiple sexual partners
- Sex with someone at risk for HIV
- History of STD
- Drug use with sex
- Buying or selling sex
- Sharing injection equipment

These percentages were translated into risk scores utilizing the same methodology used to calculate morbidity scores. Total scores were then listed in rank order. See Appendix 2 in the Area Epidemic Profile for more details.

How is Needs Assessment Data Used? Needs assessment data could be used to justify an increase to the behavioral risk score. After recording the morbidity and risk scores for a subpopulation, needs assessment findings could be used to increase the risk score by 25% to denote a higher incidence and/or additional risk behaviors than were reported in the Area Epidemic Profile for the subpopulation.